# REPORT TO THE

# TWENTY-SECOND LEGISLATURE

# STATE OF HAWAII

# 2004

**PURSUANT TO**
**SECTION 321-195, HAWAII REVISED STATUTES,**
**REQUIRING A REPORT BY THE**
**DEPARTMENT OF HEALTH ON**
**IMPLEMENTATION OF THE**
**STATE PLAN FOR SUBSTANCE ABUSE**


**PREPARED BY:**

**ALCOHOL AND DRUG ABUSE DIVISION**

**DEPARTMENT OF HEALTH**
**STATE OF HAWAII**



**JANUARY 2004**

# EXECUTIVE SUMMARY

The Fiscal Year 2002-03 annual report for the Department of Health, Alcohol and Drug Abuse Division (ADAD) is submitted pursuant to Section 321-195, Hawaii Revised Statutes.

The agency's mission is to provide the leadership necessary for the development and delivery of quality substance abuse prevention and treatment services for Hawaii residents. ADAD plans, coordinates, provides technical assistance, and establishes mechanisms for training, data collection, research and evaluation to ensure that resources are utilized in the most effective and efficient manner possible. ADAD is the primary and often sole source of public funds for substance abuse prevention and treatment services. ADAD's efforts are designed to promote a statewide, culturally appropriate, comprehensive system of services to meet the needs of individuals and families. (Treatment services have, as a requirement, priority admission for pregnant women, injection drug users, native Hawaiians and adult offenders.)

**Substance abuse prevention** is a dynamic and proactive process that attempts to reduce the supply and demand for alcohol and other drugs by focusing on: the agent, which is defined as alcohol, tobacco, and other legal and illegal drugs; the host, which is defined as the individual or group, their susceptibilities to alcohol and other drug-related problems, and their knowledge and attitudes that influence their behavior; and the environment, which is defined as the setting or context in which drinking and other drug-using behavior occurs or is influenced. The challenge is to reduce the demand for alcohol and other drugs. Because the agent (drugs), the host (individual or group) and the environment (society) are interactive and interdependent, prevention efforts must deal with all three simultaneously.

**Substance abuse treatment** refers to the broad range of services, including identification, intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems.

> ***Addiction*** *is a biopsychosocial disease, a distinct disorder requiring ongoing treatment and intervention, not only episodic or acute care. A person's addictive disorder cannot be addressed in isolation from addressing his or her biological, psychological or social needs. Addicted people may go on denying their alcohol and other drug problems, even when their lives are in shambles. It often takes serious trouble -- with the law, at school, at work, or in the family -- for them to make a move towards treatment. Most people think of treatment success as immediate, complete abstinence forever. Often, no provision is made for relapse, or understanding of the chronic and relapsing nature of the disease.*

**Highlights of accomplishments during Fiscal Year 2002-03 include:**

**Substance Abuse Prevention and Treatment (SAPT) Block Grant.** Secured $7,164,579 of SAPT Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for Federal Fiscal Year 2002 (i.e., State Fiscal Year 2003) to plan, implement and evaluate substance abuse prevention and

treatment activities.

**Hawaii State Incentive Grant (SIG) for Substance Abuse Prevention.** The three-year, $8.4 million Hawaii State Incentive Grant (SIG) project will continue its activities through September 2005. There are 18 community partnerships in communities throughout the State. A total of 14 research-based, "best practice" prevention programs are operating with SIG support.

**Substance abuse treatment for offenders.** During Fiscal Year 2002-2003, a total of 481 offenders were served under the contract for integrated case management services and safe, clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii. Referrals include: 35 offenders on Kauai (9 on supervised release, 22 on probation, 1 on furlough and 3 on parole), 235 offenders on Oahu (62 on supervised release, 64 on probation and 109 on parole), 134 offenders in Maui County (18 on supervised release, 89 on probation, 7 furloughees and 20 on parole), and 77 offenders on the Big Island (1 on supervised release, 70 on probation, -0- on furlough and 6 on parole).

**Substance Abuse Prevention and Treatment Services.** Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided services to adults and adolescents as follows:

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,597 adults statewide;

Residential and school-based outpatient substance abuse treatment services were provided to 1,224 adolescents statewide; and

Curriculum-based youth substance abuse prevention and parenting programs, mentoring programs, elderly effective medication management programs, underage drinking initiatives and Regional Alcohol and Drug Awareness Resource (RADAR) center served 104,429 children, youth and adults.

**Provision of Contracted or Sponsored Training.** Conducted a training program that accommodated staff development opportunities for 4,648 (duplicated health care, human service, education, criminal justice and substance abuse treatment professionals through 24 training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults.

**Programmatic and Fiscal Monitoring.** Through desk audits of providers' billings, reviews of audit reports and on-site monitoring, staff examined the expenditure of funds for compliance with SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions regarding grants, subsidies and purchases of service. Provided technical assistance and monitored treatment and prevention programs statewide which included desk audits and on-site reviews of the fiscal operations of 42 programs, and reviews of audit reports from 23 agencies to ensure fiscal accountability based on the Departmental Fiscal Monitoring Manual. (Patient records are subject to provisions for "Confidentiality of Alcohol and Drug Abuse Patient Records" delineated in 42 CFR Part 2; security and confidentiality protections to protect health information are contained in the Health Insurance Portability and Accountability Act of 1996.)

**Certification of Professionals and Accreditation of Programs.** Processed 496 applications, administered 114 written and 104 oral exams and certified 54 applicants as substance abuse

counselors, bringing the total number of certified substance abuse counselors to 430.

Conducted a total of 27 accreditation reviews and accredited 17 organizations, some of which have multiple (residential and outpatient) accreditable programs.

**Prevention Information System.** ADAD has continued use of the Minimum Data Set (MDS) to collect demographic and process information from contracted service providers. The data has been used in conjunction with quarterly and year-end reports and on-site monitoring, to measure compliance with contracts and to fulfill reporting requirements.

**Policy development and legislation**. Prepared informational briefs and testimonies on legislation addressing substance abuse related policies in public health, human services, education, employment, housing and criminal justice systems.

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# ALCOHOL AND DRUG ABUSE DIVISION

The Alcohol and Drug Abuse Division (ADAD) is the primary and often sole source of public funds for substance abuse treatment. ADAD's treatment efforts are designed to promote a statewide culturally appropriate, comprehensive system of services to meet the treatment and recovery needs of individuals and families. Treatment services have, as a requirement, priority admission for pregnant women and injection drug users.

# ALCOHOL AND DRUG ABUSE DIVISION

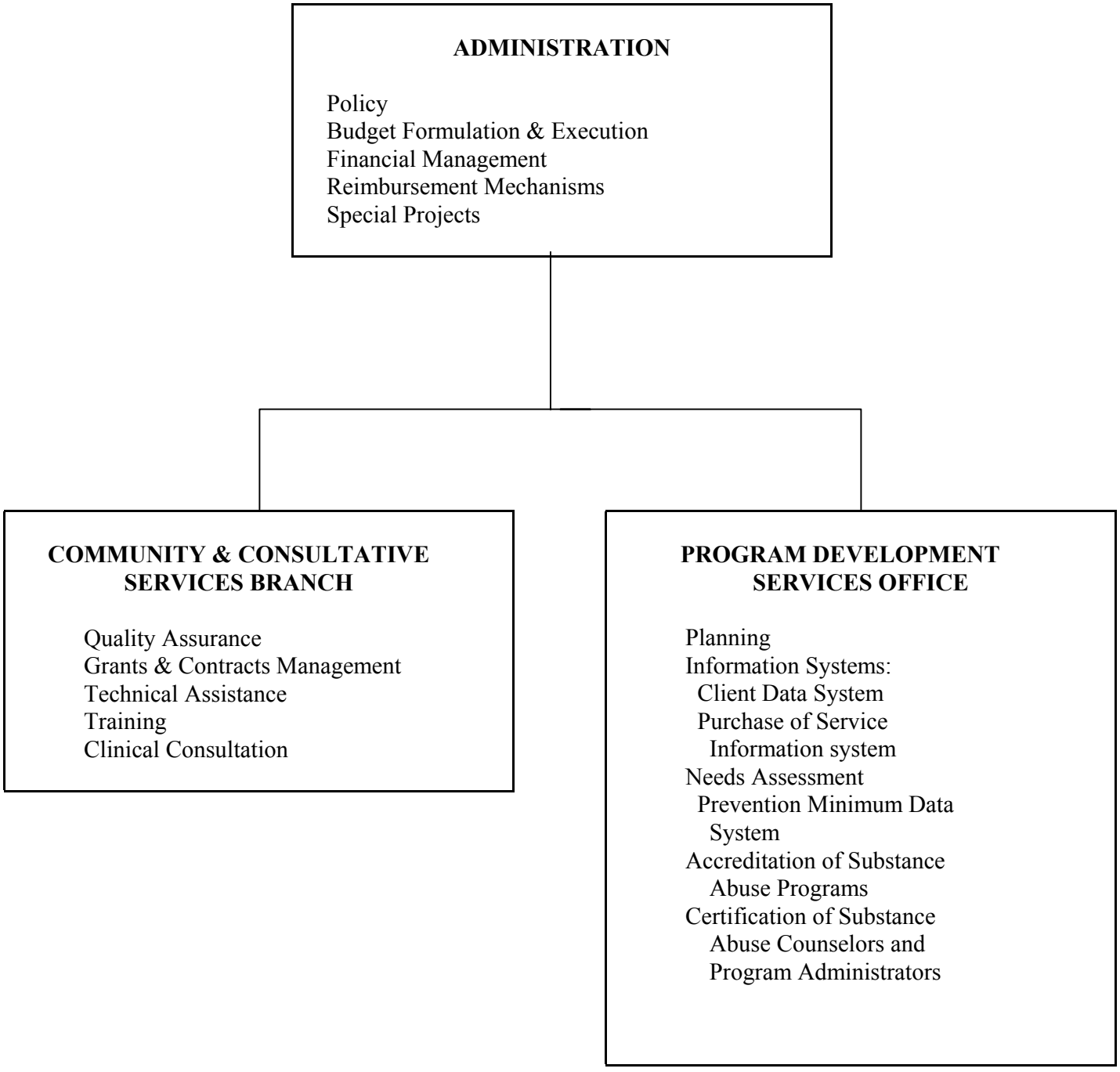
**MISSION:** ***To provide the leadership necessary for the development and delivery of quality substance abuse prevention, intervention and treatment services for the residents of the State of Hawaii.***

The State of Hawaii, Department of Health's (DOH) interest in programs and services to alcohol abusers dates back to 1955, when a part-time clinic was established and supported by 10 percent of the liquor license fees collected on Oahu. It became a full-time clinic in 1959 and, in 1965, was transferred to the Mental Health Division. In 1971, the Governor created and authorized the Governor's Ad Hoc Committee on Substance Abuse which became the Hawaii Advisory Commission on Drug Abuse and Controlled Substances (HACDACS) authorized by Chapter 329, Hawaii Revised Statutes. The State Substance Abuse Agency was attached to the Office of the Governor until 1975 when its functions were transferred to the DOH. The Alcohol and Drug Abuse Branch (ADAB) was formally organized within the Mental Health Division in 1976. ADAB incorporated the former alcoholism clinic and the substance abuse agency.

As part of a departmental reorganization in 1989, three divisions were established and assigned to a newly-established administration headed by the Deputy Director for Behavioral Health Services. The three divisions, two of which were formerly branches subsumed within the Mental Health Division, are now the Adult Mental Health Division, the Alcohol and Drug Abuse Division and the Child and Adolescent Mental Health Division.

The responsibilities of the DOH with respect to substance abuse are delineated under Section 321-193, Hawaii Revised Statutes.

**ALCOHOL AND DRUG ABUSE DIVISION**



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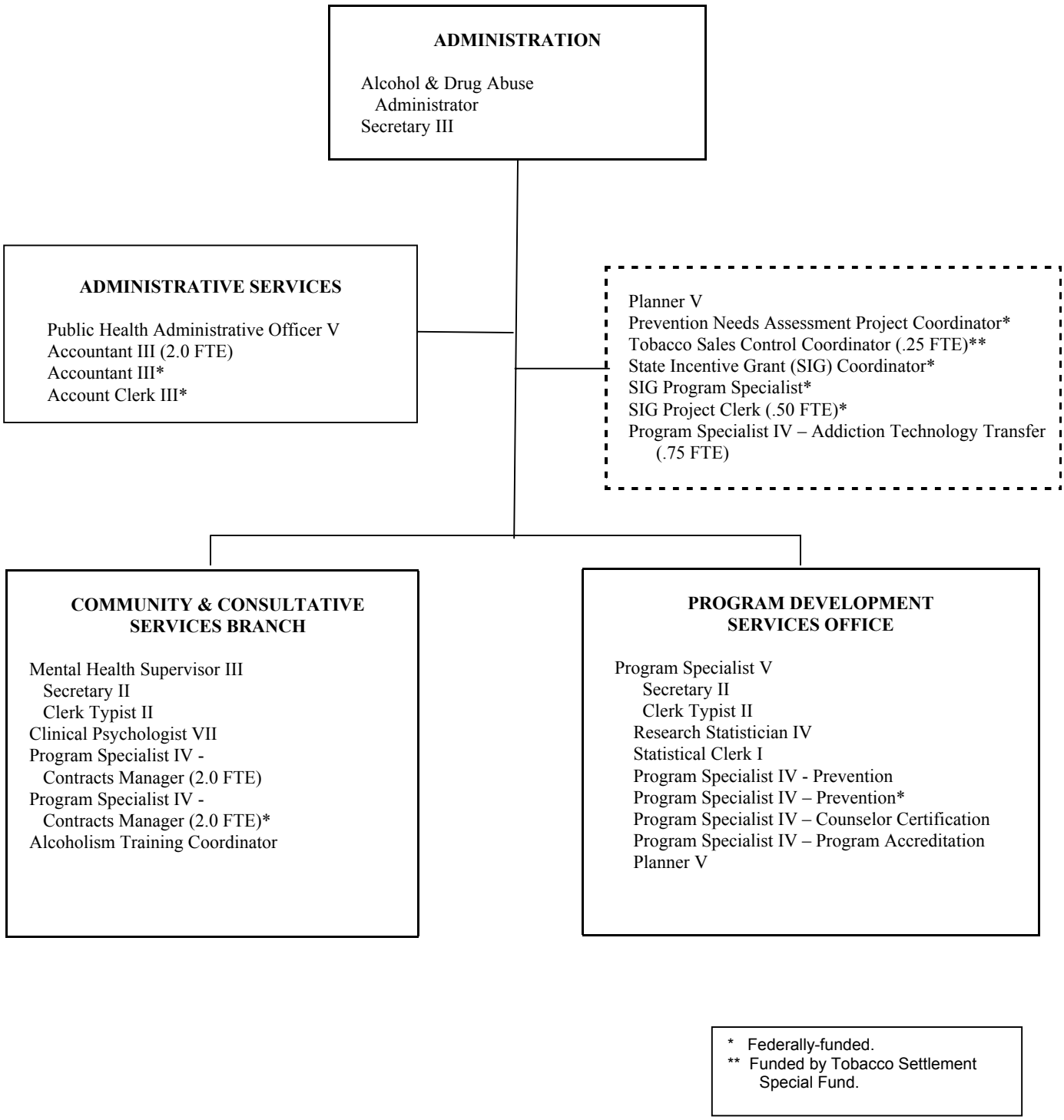



* Federally-funded.
** Funded by Tobacco Settlement Special Fund.

**ALCOHOL AND DRUG ABUSE DIVISION**

*ADAD's primary functions include:*

***The Alcohol and Drug Abuse Division (ADAD) plans, coordinates, provides technical assistance, and establishes mechanisms for training, data collection, research and evaluation to ensure that statewide substance abuse resources are utilized in the most effective and efficient manner possible.***

**GRANTS AND CONTRACTS MANAGEMENT**

**CLINICAL CONSULTATION**

**QUALITY ASSURANCE:**

- **TRAINING**
- **ACCREDITATION OF SUBSTANCE ABUSE TREATMENT PROGRAMS**
- **CERTIFICATION OF SUBSTANCE ABUSE COUNSELORS AND PROGRAM ADMINISTRATORS**
- **PREVENTION ACTIVITIES**

**POLICY DEVELOPMENT**

**PLANNING**

**COORDINATION**

**INFORMATION SYSTEMS:**

- **TREATMENT CLIENT DATA SYSTEM**
- **PREVENTION MINIMUM DATA SET**
- **NEEDS ASSESSMENTS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES**

## HIGHLIGHTS OF ACCOMPLISHMENTS AND ACTIVITIES
## July 1, 2002 to June 30, 2003

### Grants and Contracts

**Substance Abuse Prevention and Treatment (SAPT) Block Grant.** Secured $7,164,579 of SAPT Block Grant funds administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration for Federal Fiscal Year 2002 (i.e., State Fiscal Year 2003) to plan, implement and evaluate activities to prevent and treat substance abuse.

**Hawaii State Incentive Grant (SIG) for Substance Abuse Prevention.** The three-year, $8.4 million Hawaii State Incentive Grant (SIG) project will continue its activities through September 2005. There are 18 community partnerships in communities throughout the State. A total of 14 research-based, "best practice" prevention programs are operating with SIG support.

**Substance abuse treatment for offenders.** During Fiscal Year 2002-2003, a total of 481 offenders were served under the contract for integrated case management services and safe, clean and sober housing in the City and County of Honolulu and the counties of Kauai, Maui and Hawaii. Referrals include: 35 offenders on Kauai (9 on supervised release, 22 on probation, 1 on furlough and 3 on parole), 235 offenders on Oahu (62 on supervised release, 64 on probation and 109 on parole), 134 offenders in Maui County (18 on supervised release, 89 on probation, 7 furloughees and 20 on parole), and 77 offenders on the Big Island (1 on supervised release, 70 on probation, -0- on furlough and 6 on parole).

### Studies and Surveys

**Hawaii tobacco sales to minors.** Tobacco sales to minors in Hawaii are among the lowest in the nation. Findings in this year's survey show that sales decreased compared to last year in Hawaii. The joint program with the University of Hawaii Cancer Research Center of Hawaii and ADAD monitors the State's compliance with the Synar Regulation of the federal Public Health Service Act of 1993. (The Synar Regulation, a federal mandate, requires each state to document a rate of tobacco sales to minors of no more than 20% or risk losing millions in federal funds for alcohol and other drug abuse prevention and treatment services.)

Since this program began eight years ago, the rates of noncompliance decreased from 45% in 1996 to 6.2% in 2003. Through hard work, an aggressive, engaging anti-smoking campaign, extensive merchant education and a print campaign that recognizes local merchants for compliance or noncompliance with the sales to minors law, Hawaii has one of the lowest rates of selling tobacco to minors in the nation.

The Hawaii Year 2003 survey found that: 6.2% of all the stores inspected, in the scientifically-based random sample of retail outlets statewide, sold cigarettes to minors; the non-compliance rate for the City and County of Honolulu is 4.9%; and Kauai and Maui County rates of sales are 9.1% and 3.7% respectively, while the Big Island's rate that was 25% last year decreased to 14.3% this year.

Two significant factors associated with lower tobacco sales to minors are: whether the clerk requested identification (higher percentage of sales when not requested); and whether the clerk requested

identification or age (higher percentage of sales when not requested).

**The 2002 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study.** In the Spring of 2002, the State of Hawaii Department of Health, Alcohol and Drug Abuse Division, and the University of Hawaii Speech Department collaborated in a study to assess prevalence and trends in substance use, treatment needs and risk and protective factors that predict substance use and abuse among Hawaii public and private school students statewide.

The 2002 study indicates that almost 11% (11,319) of the students statewide in both public and private schools grades six through twelve are estimated to need treatment for either alcohol or drug abuse. The areas of greatest need are: Hawaii district 13.7% (1,787 students), Maui district 14.4% (1,558 students) and Windward Oahu 14.3% (1,224 students). The study further identified a total of 671 (12.7%) students in Kauai district, 1,593 (8.9%) students in Leeward Oahu, 1,277 (8.1%) students in Central Oahu, and 1,364 (8.3%) students in Honolulu district.

The results of the *2002 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study* indicate that substance use continues to be a significant problem affecting the youth of Hawaii, but the stabilization patterns in most illicit drug use, the current downward trends in alcohol and cigarette use, and the continuing decline in treatment needs all are encouraging. Effective prevention and treatment programs require the combined efforts of communities, law enforcement, families, media, and ongoing school-based substance abuse programs.

Recommendations based on the findings from *The 2002 Hawaii Student Alcohol, Tobacco, and Other Drug Use Study (1987-2002): Adolescent Prevention and Treatment Needs Assessment* (Pearson, 2003) are as follows:

- Make substance abuse prevention a priority in every community.
- Strengthen the family's role and skills in substance abuse prevention efforts.
- Ensure that every adolescent who has substance abuse or dependence problems gets treatment.
- Increase mass media coverage on substance abuse prevention and treatment.
- Increase community awareness of the serious consequences of underage alcohol usage.
- Strengthen substance abuse prevention programs in the school and the community.

**2003 Survey of Retail Alcohol Sales to Underage Persons.** The survey was conducted by the Department of Health and Mothers Against Drunk Driving (MADD) on Oahu. While the rate at which minors were able to buy alcohol declined slightly from 26% in 2002 to 22% in 2003, health, law enforcement and advocacy leaders remain concerned about the availability of alcohol to underage persons.

The study details the enforcement operation in which youth decoys, under the age of 21, visited 396 randomly selected Oahu outlets licensed to sell alcohol. The decoys attempted to purchase alcohol with identification that showed they were less than 21 years-of-age. Of the 396 outlets inspected, 78% (310 stores) refused to sell to decoys but 22% of the businesses (86) failed to comply with the law and sold to underage buyers.

At locations where alcohol was illegally sold, a police officer, who had observed the sale, issued a citation to the store clerks. County penalties vary. In Honolulu, selling alcohol to a minor is a misdemeanor and carries a fine of up to $2,000 and up to one year in jail. The storeowner or licensee

who sells alcohol to a minor faces a penalty of up to $2,000 or revocation or suspension of the liquor license.

Five factors were identified as significantly impacting the ability of minors to buy alcohol. They included: asking for identification, posting warning signs, the age of the buyer, the gender of the buyer and the display of promotional materials within the store.

- 91% of the time that the clerk asked for identification from the youth decoy, the youth decoy was not able to purchase alcohol.
- Outlets that had "We Card" signs posted (33%) were more likely to sell alcohol to a youth decoy than those who did not display such signs (15%).
- Clerks were more likely to sell to a 20-year-old decoy (26 %) than the 18-year-old decoy (20%).
- The female decoy (22%) was more likely to be able to purchase than the male decoy (6%).
- Outlets that displayed alcoholic beverage promotional material (32%) were more likely to sell than those that did not (17%).

Of the 396 outlets surveyed, there were 180 convenience stores (45.7%), 90 grocery stores (22.7%), 57 liquor stores (14.3%), 48 gas stations (12%), and 21 drug/other stores (5.3%). The unannounced inspections were conducted for the Alcohol and Drug Abuse Division of DOH by Mothers Against Drunk Driving in cooperation with the Honolulu Police Department.

## Provision of Contracted Substance Abuse Prevention and Treatment Services

**Substance Abuse Prevention and Treatment Services.** Through contracts with community-based substance abuse prevention and treatment agencies, ADAD provided services to adults and adolescents as follows:

A continuum of residential, outpatient, day treatment and therapeutic living services were provided to 2,597 adults statewide;

Residential and school-based outpatient substance abuse treatment services were provided to 1,224 adolescents statewide; and

Curriculum-based youth substance abuse prevention and parenting programs, mentoring programs, elderly effective medication management programs, underage drinking initiatives and Regional Alcohol and Drug Awareness Resource (RADAR) center served 104,429 children, youth and adults.

## Provision of Contracted or Sponsored Training

Conducted a training program that accommodated staff development opportunities for 4,648 (duplicated health care, human service, education, criminal justice and substance abuse treatment professionals through 24 training sessions, courses and workshops in topics relating to substance abuse prevention and treatment for adolescents and adults.

## Programmatic and Fiscal Monitoring and Request for Proposal (RFP) Process

A total of $14.9 million in State General Funds, federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds and categorical federal grants are expended under 79 contracts for substance abuse prevention and treatment services with 43 nonprofit organizations annually.

Through desk audits of providers' billings, reviews of audit reports and on-site monitoring, staff examined the expenditure of funds for compliance with SAPT Block Grant restrictions, State General Fund expenditure guidelines and statutory provisions regarding grants, subsidies and purchases of service. (Patient records are subject to provisions for "Confidentiality of Alcohol and Drug Abuse Patient Records" delineated in 42 CFR Part 2; security and confidentiality protections to protect health information are contained in the Health Insurance Portability and Accountability Act of 1996.)

Provided technical assistance and monitored treatment and prevention programs statewide which included desk audits and on-site reviews of the fiscal operations of 42 programs, and reviews of audit reports from 23 agencies to ensure fiscal accountability based on the Departmental Fiscal Monitoring Manual.

Conducted on-site reviews of the programmatic operations of treatment and prevention agencies statewide and reviewed their monthly, quarterly and year-end reports to ensure compliance with contract requirements for the delivery of services.

Participated in meetings of the State Procurement Office Purchase of Service Team (POST) to standardize RFP requirements, instructions and forms for purchase of service contracts.

## Certification of Professionals and Accreditation of Programs

Processed 496 applications, administered 114 written and 104 oral exams and certified 54 applicants as substance abuse counselors, bringing the total number of certified substance abuse counselors to 430.

Conducted a total of 27 accreditation reviews and accredited 17 organizations, some of which have multiple (residential and outpatient) accreditable programs.

Continued drafting of administrative rules for the accreditation of substance abuse programs in consultation with accredited substance abuse treatment programs, treatment professionals and consumer groups.

## Prevention Information System

ADAD has continued use of the Minimum Data Set (MDS) to collect demographic and process information from contracted service providers. The data has been used in conjunction with quarterly and year-end reports and on-site monitoring, to measure compliance with contracts and to fulfill reporting requirements.

## Legislation

Legislation passed during the 2003 Legislative Session that address substance abuse prevention and/or treatment related issues included:

**Act 95-03. Criminal Record History Checks.** Implements the recommendations of the criminal history record check working group established pursuant to Act 263, SLH 2001, to address inconsistencies and duplicative statutory language authorizing record checks for employment background checks, certifications and licensing of individuals

**Act 69-03. Alcoholic Beverages.** Imposes civil third-party liability on persons selling or providing alcoholic beverages or on persons owning or controlling premises on which alcoholic beverages are consumed, for damages caused by intoxication of persons under age 21. Prohibits certain subrogation claims. Prohibits adults from providing liquor for consumption or use by a minor. Exempts sales of alcoholic beverages licensed under Chapter 281. Authorizes each county liquor commission to take action against unauthorized purchase of intoxicating liquor. Sets minimum fine for repeat violators, and separate penalties for minors subject to the jurisdiction of the family court.

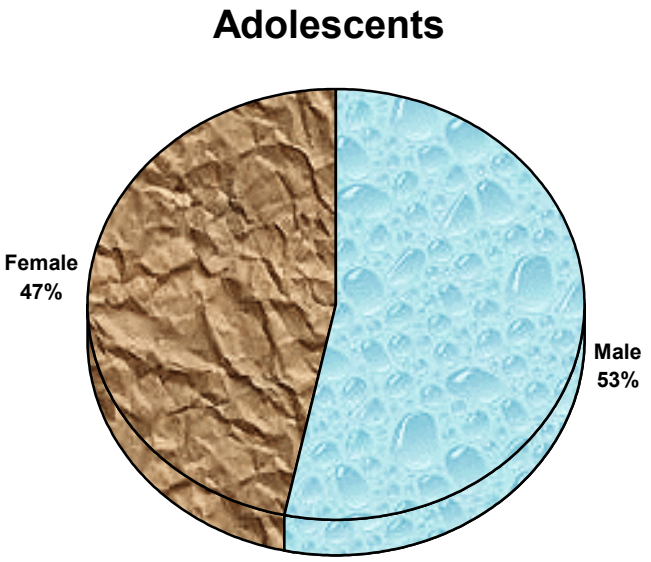
**Act 200-03. State Budget.** Appropriates $2.2 million of State General Funds to be expended by the Department of Health (DOH), for substance abuse treatment and case management services for offenders on supervised release, probation, furlough and parole in Fiscal Year 2003-04. (Act 175-02 appropriated funds from the Emergency and Budget Reserve Fund for substance abuse treatment and case management services for offenders on supervised release, probation, furlough and parole, to be expended during FY 2002-03.)

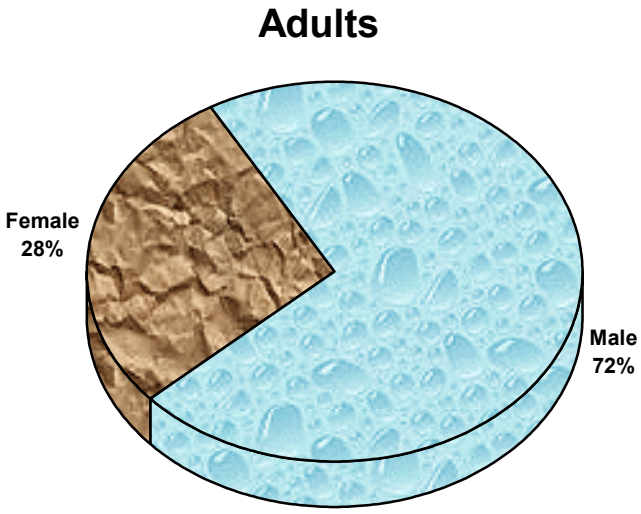
**SCR 116 SD1 HD1. Study of Mandatory Health Insurance Coverage for Mental Health and Alcohol and Drug Abuse Treatment.** Requests that the Auditor assess both the social and financial effects of:

(1) The mandated coverage proposed under S.B. No. 1321, H.D. 1, which amends the definition of "serious mental illness" in chapter 431M, HRS, by replacing "bipolar mood disorder" with "bipolar types I and II" and including delusional disorder, major depression, obsessive compulsive disorder, and dissociative disorder; and

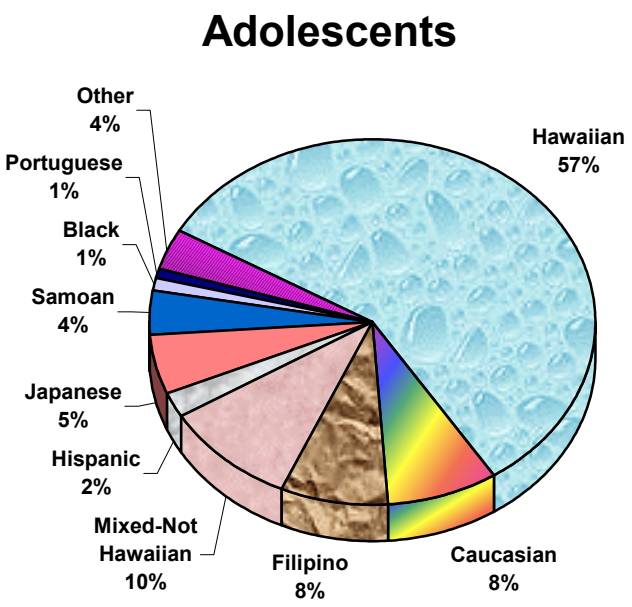
(2) Requiring treatment for alcohol dependency and drug dependency, at rates and on terms and conditions no less favorable than those applicable to treatment for medical and surgical conditions currently required to be covered by health insurers.

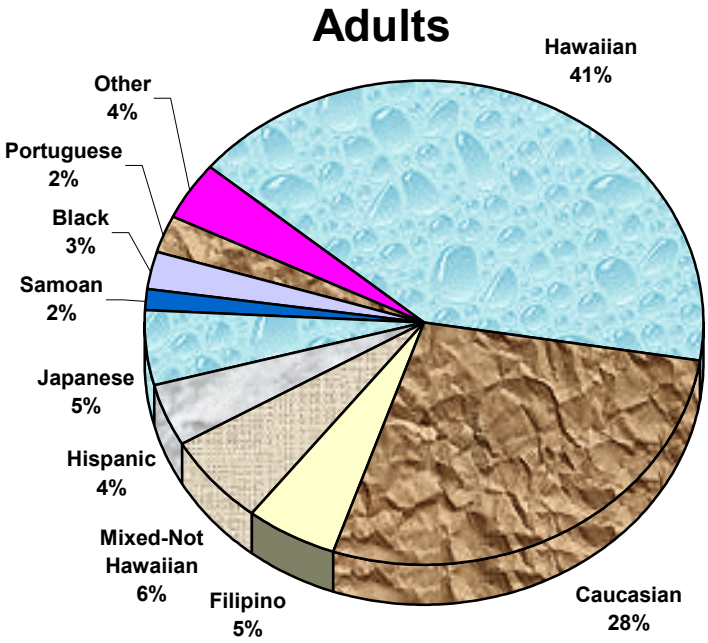
**CLIENT DATA SYSTEM SUBSTANCE ABUSE TREATMENT**
**ADMISSIONS FOR STATE FY 2003**
**ADAD-FUNDED ADMISSIONS BY GENDER**



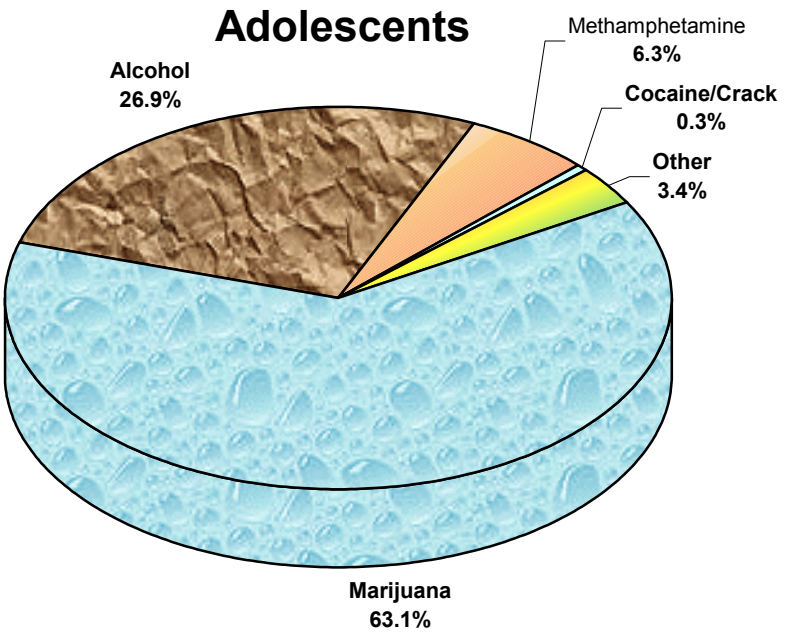



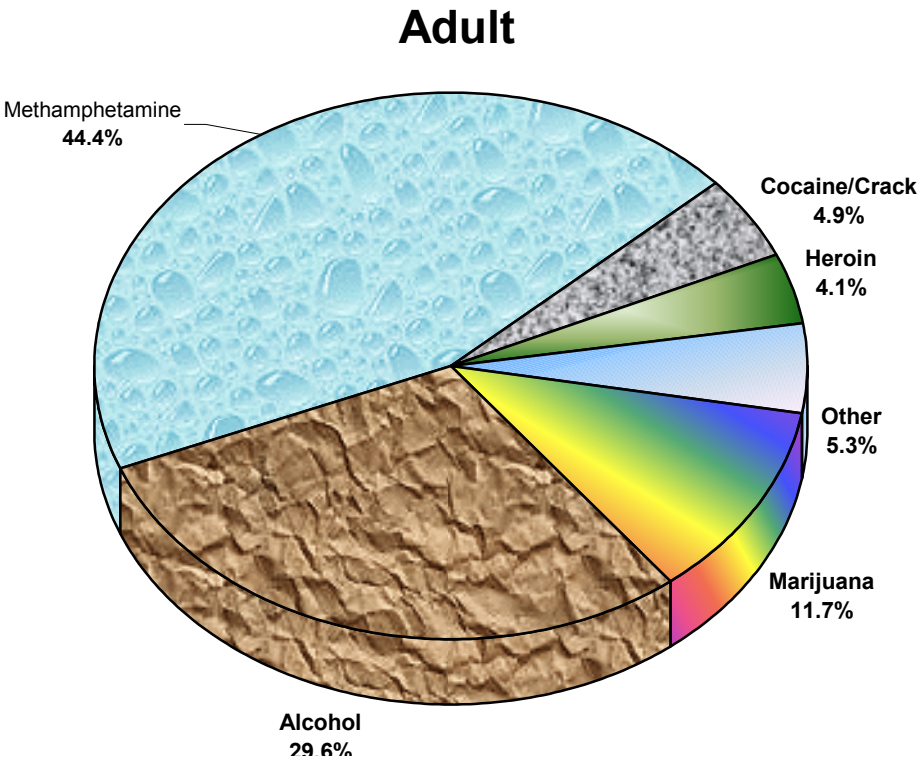
**CLIENT DATA SYSTEM SUBSTANCE ABUSE TREATMENT**
**ADMISSIONS FOR STATE FY 2003**
**ADAD-FUNDED ADMISSIONS BY ETHNICITY**



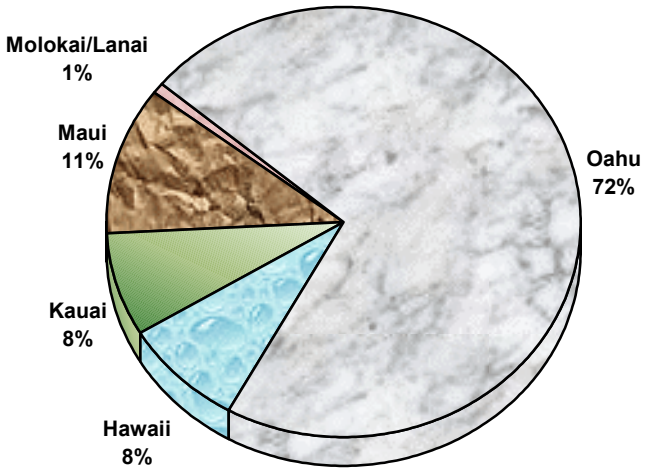
**CLIENT DATA SYSTEM SUBSTANCE ABUSE TREATMENT ADMISSIONS FOR STATE FY 2003**
**ADAD-FUNDED ADMISSIONS BY PRIMARY SUBSTANCE**



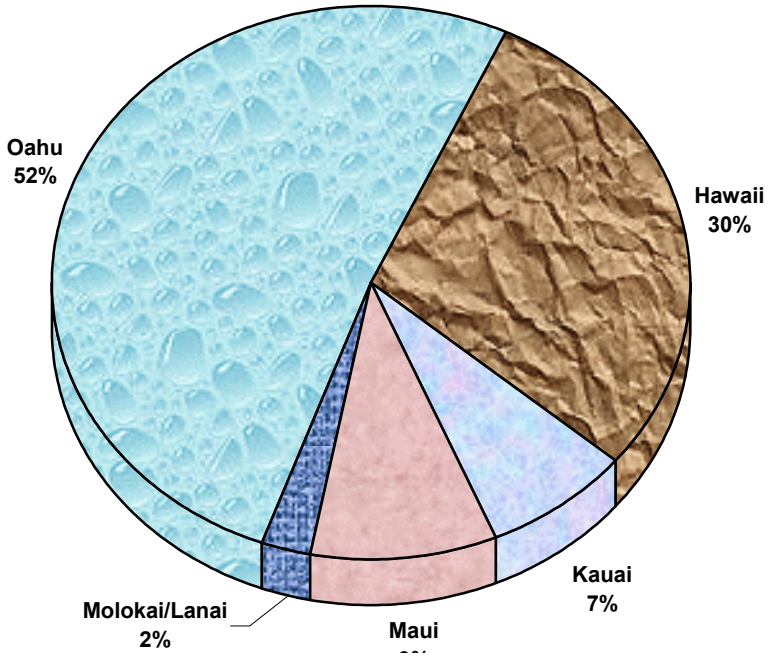



**CLIENT DATA SYSTEM SUBSTANCE ABUSE TREATMENT**
**ADMISSIONS FOR STATE FY 2003**
**ADAD-FUNDED ADMISSIONS BY RESIDENCY**

## Adolescents




## Adults



## ADOLESCENT SUBSTANCE ABUSE TREATMENT
## PERFORMANCE OUTCOMES

During State Fiscal Year 2003, (July 1, 2002 to June 30, 2003), six-month follow-ups were completed for a sample of 712 adolescents. Listed below are the outcomes for this sample.

| MEASURE | PERFORMANCE OUTCOME ACHIEVED SIX-MONTH |
|---|---|
| Employment/School/Vocational Training | 97.0% |
| No arrests since discharge | 90.4% |
| No substance use in 30 days prior to follow-up | 52.4% |
| No new substance abuse treatment | 81.9% |
| No hospitalizations | 96.8% |
| No emergency room visits | 94.7% |
| No psychological distress since discharge | 81.0% |
| Stable living arrangements | 96.6% |

## ADULT SUBSTANCE ABUSE TREATMENT
## PERFORMANCE OUTCOMES

During State Fiscal Year 2003, (July 1, 2002 to June 30, 2003), six-month follow-ups were completed for a sample of 1,383 adults. Listed below are the outcomes for this sample.

| MEASURE | PERFORMANCE OUTCOME ACHIEVED SIX-MONTH |
|---|---|
| Employment/School/Vocational Training | 46.2% |
| No arrests since discharge | 89.1% |
| No substance use in 30 days prior to follow-up | 63.5% |
| No new substance abuse treatment | 78.5% |
| No hospitalizations | 92.9% |
| No emergency room visits | 91.5% |
| Participated in self-help group (NA, AA, etc.) | 43.7% |
| No psychological distress since discharge | 84.2% |
| Stable living arrangements | 82.3% |

# ADDICTION

The Diagnostic and Statistical Manual - IV (DSM-IV) describes addiction as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

Substance is often taken in larger amounts or over longer period than intended.

Persistent desire or unsuccessful efforts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.

***Addiction is a biopsychosocial disease, a distinct disorder requiring ongoing treatment and intervention, not only episodic or acute care. A person's addictive disorder cannot be addressed in isolation from addressing his or her biological, psychological or social needs.***

Important social, occupational, or recreational activities given up or reduced because of substance abuse.

Continued substance use despite knowledge of having a persistent or recurrent psychological or physical problem that is caused or exacerbated by use of the substance.

Tolerance, as defined by either:

Need for markedly increased amounts of the substance in order to achieve intoxication or desired effect; or

Markedly diminished effect with continued use of the same amount.

Withdrawal, as manifested by either:

Characteristic withdrawal syndrome for the substance; or

The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

# TRENDS AND ISSUES THAT IMPACT ALCOHOL AND DRUG PROBLEMS

***Linkages with substance abuse prevention and treatment services in Federal, State and local level initiatives in health care, criminal justice and welfare reform reflect a growing awareness of the extent to which substance abuse impacts the individual, the family and the community.***

***Strengthening core services and enhancing the continuum of substance abuse services available throughout the State will improve the accessibility, quality and availability of services.***

Socio-economic conditions that alter accustomed living patterns.

Shortage of trained substance abuse professionals and paraprofessionals.

Fiscal constraints at both the State and Federal levels.

Availability of drugs, including cocaine, marijuana, crystal methamphetamine and heroin.

Number of drug and alcohol exposed infants.

Risk of HIV, TB, Hepatitis B and Hepatitis C infection among substance abusing populations.

Increased focus on accountability and outcome objective monitoring and evaluation.

The Federal role and influence in setting substance abuse policy direction.

Shorter lengths of treatment duration with advent of managed care.

Increased prevalence of adolescent substance abuse.

Lack of "treatment on demand" for the public client.

Increased prevalence of substance abuse among the child welfare population.

Linkage between substance abuse treatment and components within the criminal justice system.

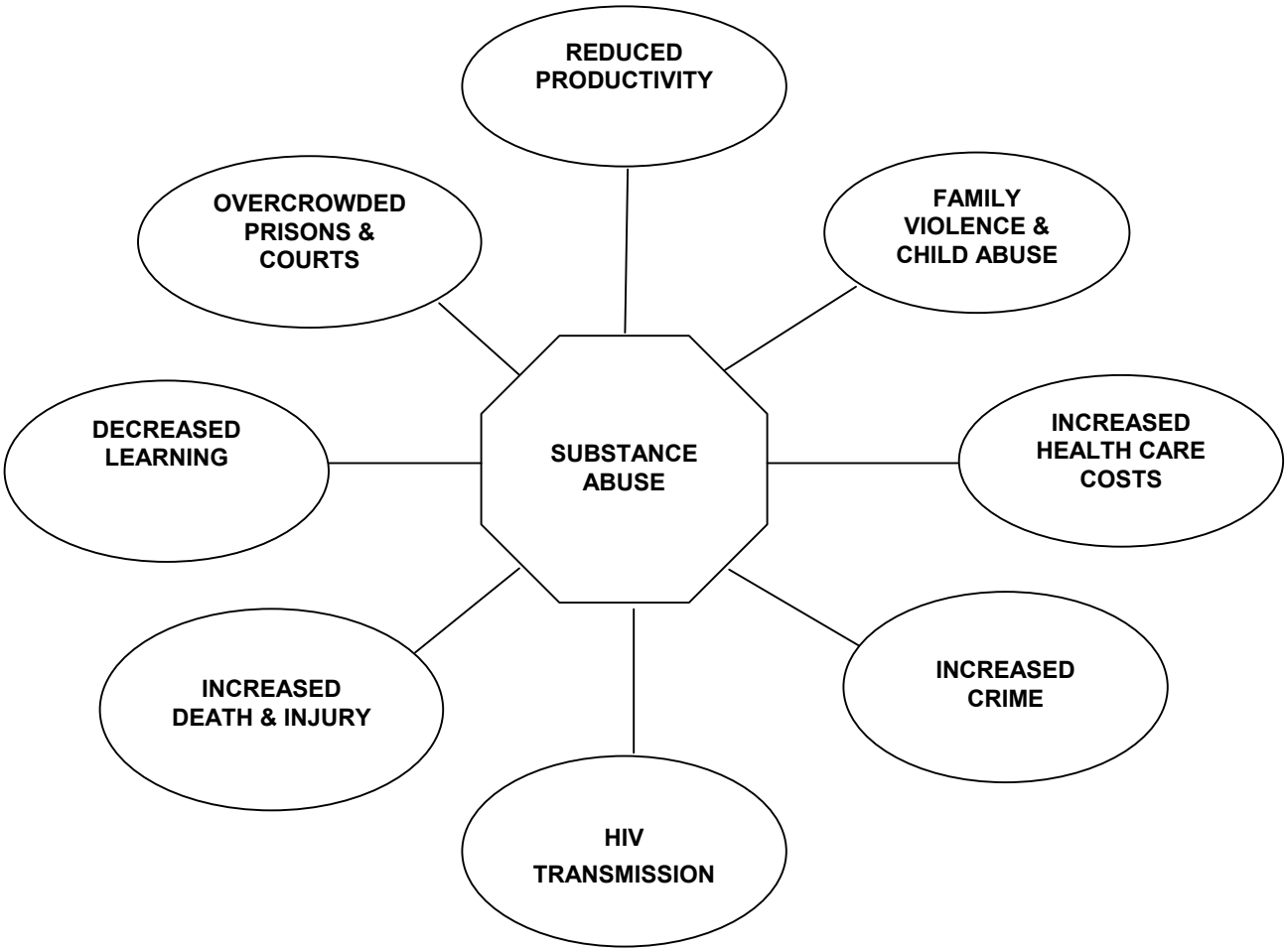
Multi-diagnosed clients.

Lack of sufficient residential treatment capacity for chronic public clients.

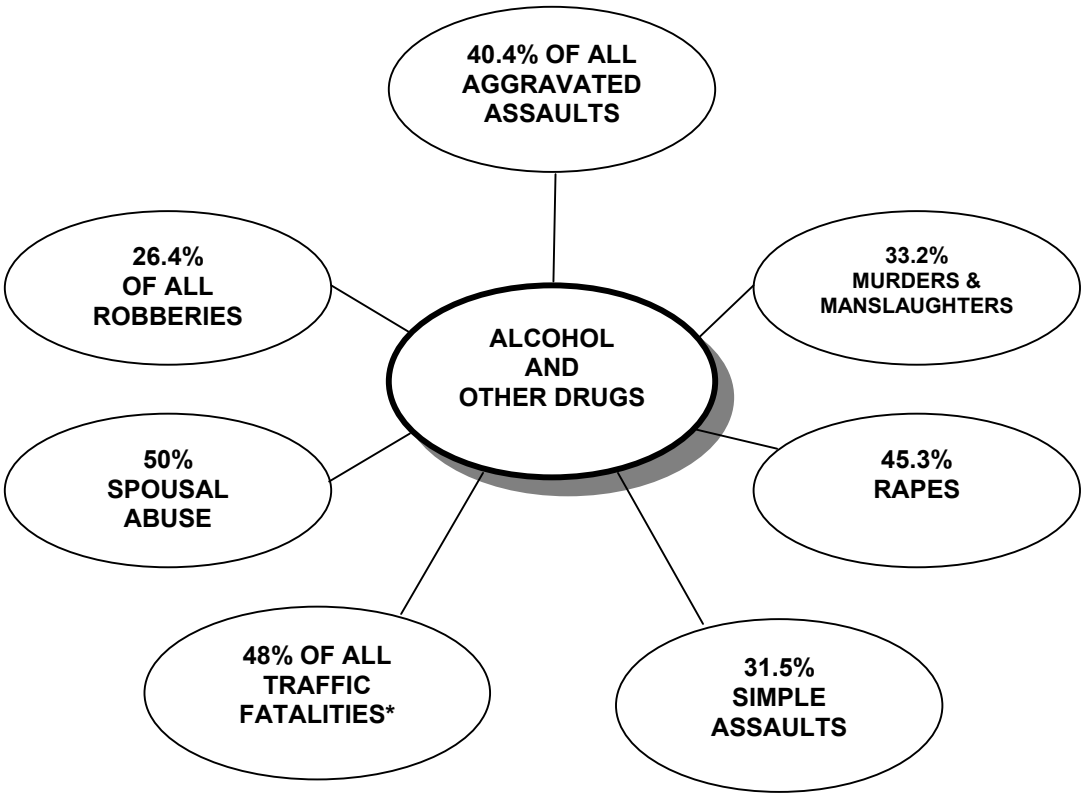
Uniqueness of public sector client needs.

Retention of alcohol and other drug abuse treatment and prevention as a basic health care benefit.

**PEOPLE ARE AFFECTED BY**
**ALCOHOL AND OTHER DRUG ABUSE IN MANY WAYS**



## ALCOHOL AND OTHER DRUG USE CONTRIBUTES TO CRIMES AND ACCIDENTS




Source: Bureau of Justice Statistics, Drugs and Crime Facts, 1992.
*U.S. Department of Transportation.

# 1998 ESTIMATED NEED*
# FOR ADULT ALCOHOL AND DRUG ABUSE
# TREATMENT IN HAWAII

| ESTIMATE OF DEPENDENCE AND ABUSE (NEEDING TREATMENT) | | | | | |
|---|---|---|---|---|---|
| | COUNTY | | | | |
| | HONOLULU | MAUI | KAUAI | HAWAII | TOTAL |
| Population (18 Years and Over) | 668,524 | 85,645 | 41,304 | 99,941 | 895,414 |
| NEEDING TREATMENT | | | | | |
| Alcohol Only | 49,285 | 7,496 | 2,463 | 9,682 | 68,926 |
| Drugs Only | 3,476 | 1,679 | 483 | 1,509 | 7,074 |
| Alcohol and/or Drugs | 57,623 | 9,822 | 3,259 | 12,176 | 82,880 |

Source: "Hawaii 1998 Adult Telephone Household Survey of Substance Use" prepared by the University of Hawaii at Manoa School of Public Health for the Department of Health - Alcohol and Drug Abuse Division. (Based on 1990 U.S. Census Data and 1998 estimates.)

Findings of the 1998 Adult Telephone Household Survey reveal that of the state's total 895,414 adult population over the age of 18, a total of 82,880 (9.3%) are in need of treatment for alcohol and/or other drugs. Comparable figures by county are as follows:

For the **City and County of Honolulu**, 57,623 (8.6%) of the total 668,524 adults on Oahu are in need of treatment for alcohol and/or other drugs. Of the 57,623 adults in need of treatment, 28,615 (49.7%) were males and 29,008 (50.3%) were females.

For **Maui County**, 9,822 (11.5%) of the 85,645 adults on Maui, Lanai and Molokai are in need of treatment for alcohol and/or other drugs. Of the total of 9,822 adults in need of treatment, 5,308 (54.0%) were males and 4,514 (46.0%) were females.

For **Kauai County**, 3,259 (7.9%) of the total 41,304 adults on Kauai are in need of treatment for alcohol and/or other drugs. Of the total 3,259 adults in need of treatment, 1,815 (55.7%) were males and 1,444 (44.3%) were females.

For **Hawaii County**, 12,176 (12.2%) of the total 99,941 adults on the Big Island are in need of treatment for alcohol and/or other drugs. Of the total 12,176 adults in need of treatment, 7,368 (60.5%) were males and 4,806 (39.5%) were females.

# 2002 ESTIMATED NEED*
# FOR ADOLESCENT (GRADES 6-12)
# ALCOHOL AND DRUG ABUSE TREATMENT
# IN HAWAII

| COUNTY/DISTRICT INFORMATION | | Need Treatment for Alcohol Abuse | | Need Treatment for Drug Abuse | | Need Treatment for Both Alcohol and Drug Abuse | | TOTAL TREATMENT NEEDS | |
|---|---|---|---|---|---|---|---|---|---|
| | Total N | % | n | % | n | % | n | % | n |
| **HONOLULU** | 58,645 | 2.3% | 1,355 | 2.8% | 1,621 | 4.3% | 2,490 | 9.3% | 5,458 |
| **□ Honolulu District** | 16,517 | 2.2% | 356 | 2.3% | 373 | 3.9% | 636 | 8.3% | 1,364 |
| **□ Central District** | 15,714 | 2.0% | 318 | 2.3% | 361 | 3.8% | 597 | 8.1% | 1,277 |
| **□ Leeward District** | 17,841 | 2.5% | 444 | 2.5% | 450 | 4.0% | 705 | 8.9% | 1,593 |
| **□ Windward District** | 8,573 | 2.8% | 237 | 5.1% | 437 | 6.4% | 552 | 14.3% | 1,224 |
| **Hawaii County/District** | 13,077 | 4.2% | 545 | 3.8% | 491 | 5.8% | 756 | 13.7% | 1,787 |
| **Kauai County/District** | 5,268 | 2.9% | 151 | 4.4% | 233 | 5.5% | 288 | 12.7% | 671 |
| **Maui County/District** | 10,813 | 2.8% | 304 | 4.2% | 457 | 7.4% | 796 | 14.4% | 1,558 |
| **All Public Schools** | 87,803 | 2.7% | 2,355 | 3.2% | 2,802 | 4.9% | 4,330 | 10.8% | 9,474 |
| **Private Schools** | 19,058 | 2.9% | 561 | 2.2% | 413 | 4.6% | 872 | 9.7% | 1,845 |
| **TOTAL STATEWIDE** | 106,861 | 2.7% | 2,916 | 3.0% | 3,215 | 4.9% | 5,202 | 10.6% | 11,319 |

*Notes: A substance abuse/dependency diagnosis is calculated based on the student's response to items that correspond with the DSM-III-R criteria, which assess a variety of negative consequences related to substance use. Students responded to abuse and dependency questions for each of the following substances: alcohol, marijuana, stimulants (cocaine, methamphetamine, speed), depressants or downers (sedatives, heroin), hallucinogens, and club drugs (ecstasy, GHB, Rohypnol, ketamine).

*Substance abuse* is indicated by at least one of the following:

(1) Continued use of the substance despite knowledge of having a persistent or recurrent problem(s) at school, home, work, or with friends because of the substance, or
(2) Substance use in situations in which use is physically hazardous (e.g., drinking or using drugs when involved in activities that could have increased the student's chance of getting hurt).

For the student to be classified as abusing a substance, at least one of the two abuse symptoms must have occurred more than once in a single month or several times within the last year. In addition, the student must not meet the criteria for dependency on that substance.

For the student to be classified as abusing a substance, at least one of the two abuse symptoms must have occurred more than once in a single month or several times within the last year. In addition, the student must *not* meet the criteria for dependency on that substance.

*Substance dependency* is the most severe diagnosis. Substance dependency is indicated by the student's response to nine different diagnostic criteria for dependency (e.g., marked tolerance, withdrawal symptoms, use of substances to relieve/avoid withdrawal symptoms, persistent desire or effort to stop use, using more than intended, neglect of activities, great deal of time spent using or obtaining the substance, inability to fulfill roles, drinking or using substances despite having problems). A student is considered dependent on the substance if he/she marked "yes" to at least three DSM-III-R symptoms and if he/she indicated that at least two of the symptoms occurred several times. The abuse estimates above include students who *either* abuse or are dependent on a particular substance. Only public school students are included in the county and district estimates.

# PRIORITY POPULATIONS

## PREGNANT AND PARENTING WOMEN AND CHILDREN

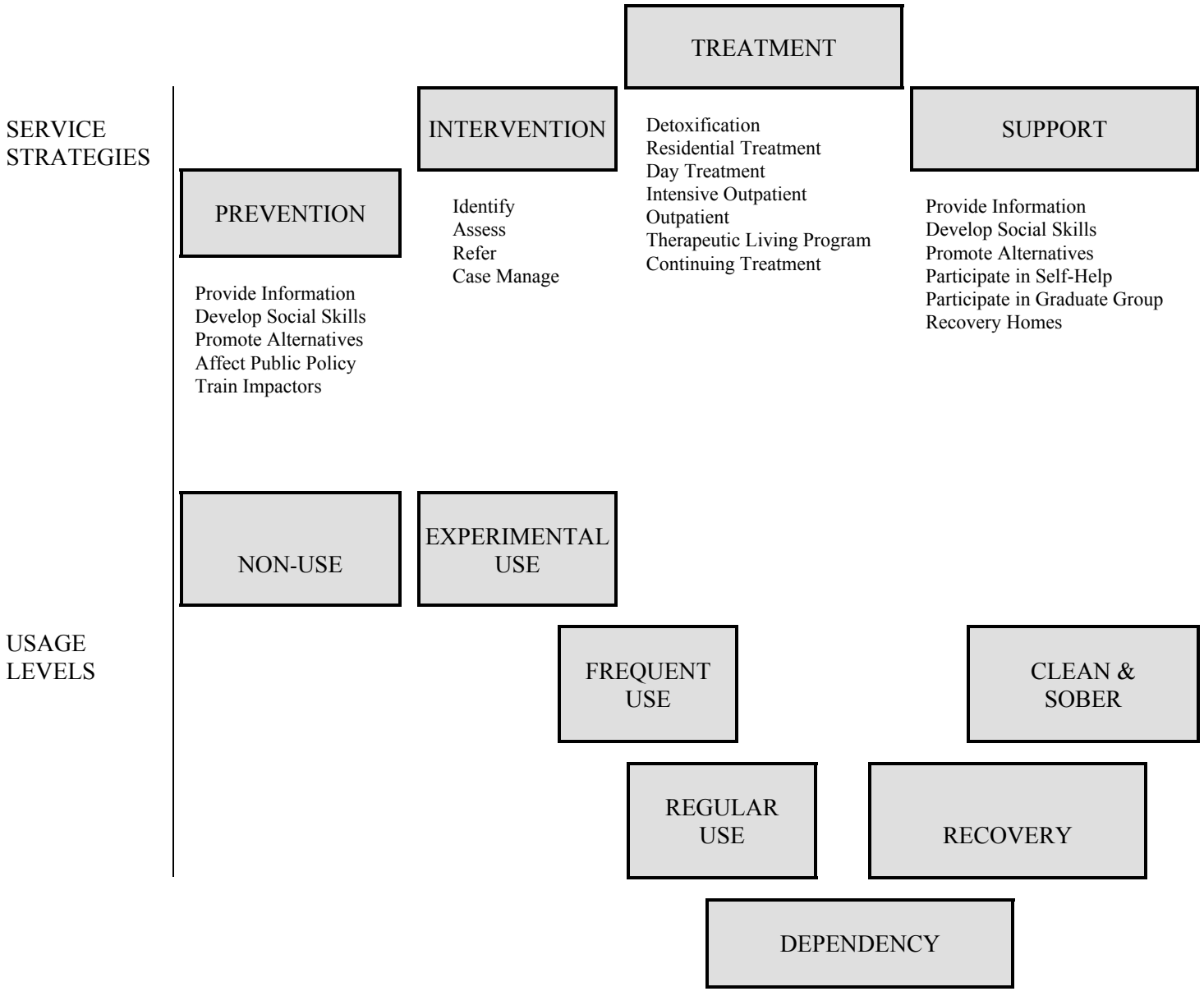
## INJECTION DRUG USERS

## NATIVE HAWAIIANS

## ADULT OFFENDERS

## CONTINUUM OF ALCOHOL AND OTHER DRUG SERVICES

To meet the need, a comprehensive continuum of alcohol and other drug treatment services is necessary. As shown below, the continuum of services includes prevention, intervention, treatment and support services. The Alcohol and Drug Abuse Division contracts out all direct services to community-based nonprofit organizations.




Source: Oregon State Office of Alcohol and Drug Abuse Programs. Alcohol & Drug Review; Vol. XI, No. 2, Summer 1991.

## COMPLIANCE AND "RELAPSE" IN SELECTED MEDICAL DISORDERS

### INSULIN DEPENDENT DIABETES

| | |
|---|---|
| Compliance with medication regimen | <50% |
| Compliance with diet and foot care | <30% |
| Retreated within 12 months | <30%-50% |

### MEDICATION DEPENDENT HYPERTENSION

| | |
|---|---|
| Compliance with medication regimen | <30% |
| Compliance with diet | <30% |
| Retreated within 12 months | <50%-60% |

### ASTHMA (ADULT)

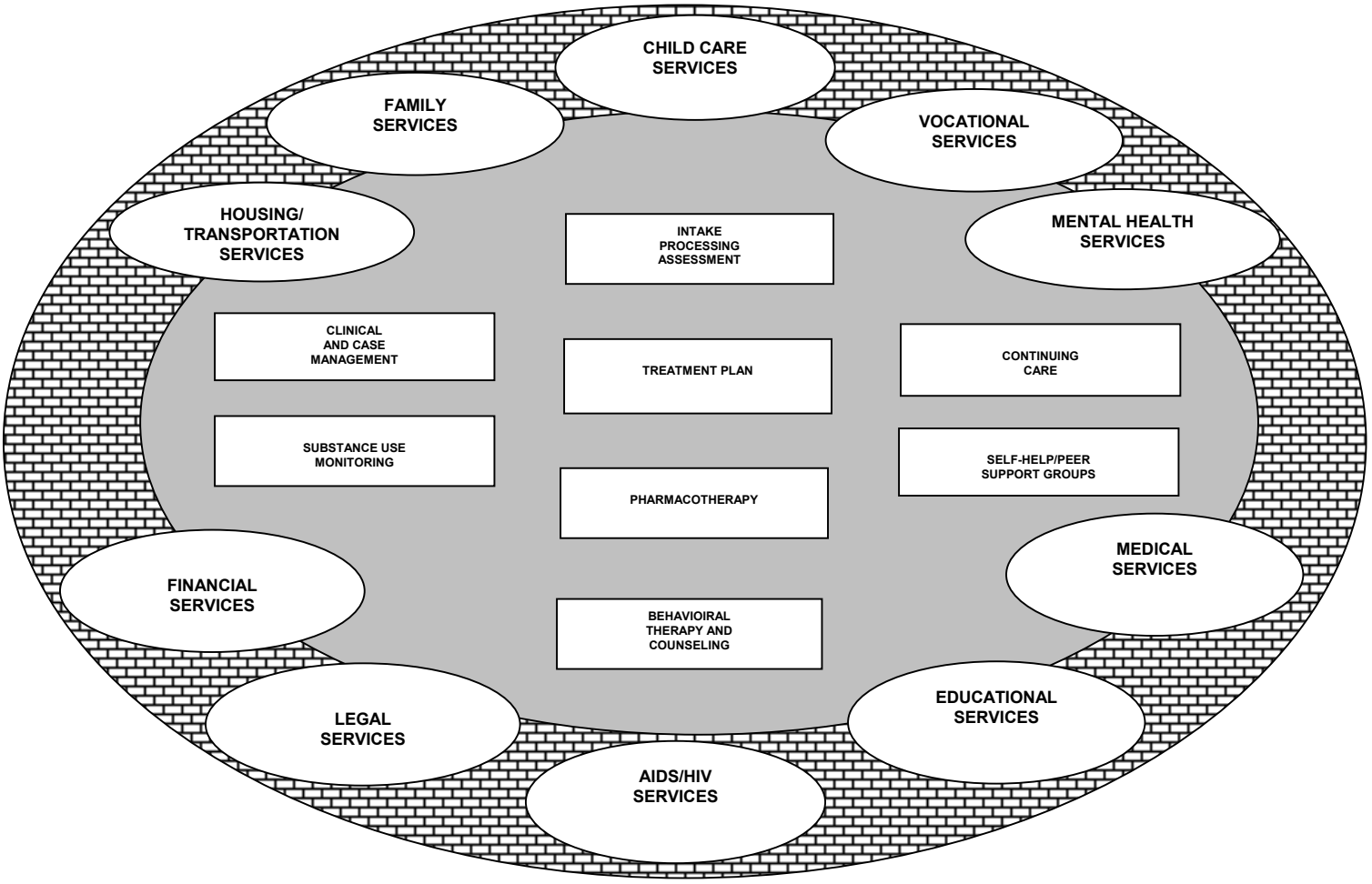
| | |
|---|---|
| Compliance with medication regimen | <30% |
| Retreated within 12 months | <60%-80% |

### ABSTINENCE ORIENTED ADDICTION TREATMENT

| | |
|---|---|
| Compliance with treatment attendance | <40% |
| Retreated within 12 months | <10%-30% |

*Physician Leadership on National Drug Policy, March 1998.

**COMPONENTS OF COMPREHENSIVE SUBSTANCE ABUSE TREATMENT**




*National Institute on Drug Abuse, Principles of Drug Addiction Treatment, October 1999*

**Modalities of treatment services**. Substance abuse specific treatment services may be provided in a variety of settings or modalities within the treatment program. The treatment modality selected will depend on the findings of the initial assessment, the determination of needs of the client, and the matching of treatment services to meet the specific needs. The modalities include:

**Detoxification**. (Medically monitored residential treatment). Around the clock medical monitoring, evaluation and treatment in a residential setting for patients who have acute and severe alcohol and other drug (AOD) use disorders and who may also have a coexisting medical or psychiatric problem. Generally involves a short to intermediate length of stay (7-45 days) and may include non-medical or social model programs with variable lengths of stay.

**Medical detoxification**. (Medically managed intensive inpatient treatment). Around the clock medically directed evaluation and treatment in an acute care inpatient setting. This level of care is appropriate for the treatment of medical and psychiatric problems that may require biomedical

treatment (such as life support) or secure services (such as locked units). Such treatment generally involves short to intermediate length of stay (7-45 days).

**Outpatient treatment services**. AOD focused treatment that includes professionally directed evaluation and treatment typically of less than 9 hours per week in regularly scheduled sessions.

**Intensive outpatient treatment services**. AOD focused, professionally directed evaluation and treatment of 9-20 hours per week in a structured program. These programs may be evening programs and frequently include some weekend programming.

**Methadone/Levo-alpha-acetyl-methadol (LAAM).** A medically supervised outpatient treatment which provides counseling while maintaining the client of the drug methadone/LAAM.

**Day treatment or partial hospitalization.** AOD-focused, professionally directed evaluation and treatment of more than 20 hours per week in a structured program. This is the most intensive of the outpatient treatment options and can be used for treating clients who demonstrate the greatest degree of dysfunction but do not require inpatient or residential treatment. Evening and weekend programming may be included.

**Short-term intensive residential treatment.** Generally 21-45 days treatment designed to teach the client how to live an AOD-free life and to provide motivation for the maintenance of such a lifestyle. Follow-up care on an outpatient basis and continued participation in peer support groups is recommended to maintain the recovery process begun in the residential setting.

**Long-term intensive residential treatment.** This long term treatment model (over 45 days) may be directed by an AOD treatment professional or may be medically directed. The model is similar to a therapeutic community model. It is appropriate for persons with multiple problems, especially those with dual disorders involving a personality and an AOD use disorder. The goal of psychosocial rehabilitation is always part of treatment.

**Therapeutic living.** A residential transitional living arrangement with minimal treatment in which residents are supervised by paid staff. Residents may work and receive education, training, or treatment in the surrounding community, although some treatment may be provided in the house. House responsibilities are shared, and rules must be followed.

## Substance abuse treatment is ...

*Addicted people may go on denying their alcohol and other drug problems, even when their lives are in shambles. It often takes serious trouble -- with the law, at school, at work, or in the family -- for them to make a move towards treatment.*

*Treatment refers to the broad range of services, including identification, intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services and follow-up for persons with substance abuse problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and/or drugs as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems.*

**Where people go to end alcohol and other drug dependency.**

**An opportunity for people to start rebuilding their lives.**

**Varied from one program to another.**

**Always clearly structured, goal-oriented and demanding.**

**A match between client and program to ensure success.**

**Consistent support and help for people on the road to recovery.**

# WHAT HAPPENS IN TREATMENT?

*Certain elements are basic to substance abuse treatment:*

**Detoxification.** The process of getting alcohol and/or drugs out of the system -- of getting "clean." Some people need medical help and counseling to go through "detox."

**Assessment.** No two substance abusers are alike in substance abuse histories or their related problems. At the start of the treatment process, these aspects of the client's life need to be evaluated to determine the best course of treatment.

During assessment, the client's substance abuse behaviors are reviewed, as are current and previous medical and psychological conditions. Other factors, such as family relations and job history, are also explored.

**Treatment plan.** Information gathered during assessment helps program staff work with incoming clients to develop an individualized treatment plan. The plan is like a contract -- it spells out treatment objectives, the recommended therapeutic services, and other activities. The plan includes the client's responsibilities, the program's responsibilities, and how progress will be measured.

**Therapeutic activities and services.** Treatment programs often address all parts of a person's life that have been disrupted by alcohol and other drugs:

> Clients diagnosed with substance abuse related health and nutritional problems receive or are referred to medical care, voluntary HIV testing and education, and Tuberculosis and Hepatitis B testing.
>
> Counseling services help clients look at the patterns of their substance abuse. In *individual therapy*, they look at the underlying causes of their addiction. In *group therapy*, among other recovering people, clients are encouraged to confront their destructive behaviors and to explore new ways of dealing with people, with emotions, and with the craving for substances. *Family counseling* helps family members understand and participate in the recovery process.
>
> Essential to recovery is learning how to spend leisure time. Through *recreational activities* clients are introduced to alcohol- and drug-free ways of enjoying themselves and contributing to the community.
>
> Programs may provide services to meet specific clients' needs: *classroom instruction* for students; literacy, remedial reading and math for clients who lack *basic skills*; *job training* for unemployed or underemployed adults; and assistance in finding *housing* for clients without a home.

**Aftercare/Continuing Care.** Aftercare is critical for a successful return to the community. It helps people continue to apply the lessons learned in treatment to their own lives:

> Before clients leave treatment, they are usually introduced to outside peer support groups like Narcotics Anonymous (NA) or Cocaine Anonymous (CA), which function like Alcoholics Anonymous (AA). These groups contribute to aftercare by allowing clients to maintain relationships with other recovering people who can help them stay alcohol- and drug-free. In addition, recovering people may return to the therapeutic program for regular group and individual counseling sessions. These aftercare services help people avoid relapse.

## PRINCIPLES OF EFFECTIVE TREATMENT*

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an

* National Institute on Drug Abuse, *Principles of Drug Addiction Treatment*, 1999.

oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

# TREATMENT PROGRAMS THAT WORK:

- **ARE AT LEAST THREE MONTHS TO A YEAR IN DURATION.**

- **ARE INTENSIVE, COMPREHENSIVE AND HIGHLY STRUCTURED.**

- **REQUIRE THERAPY FOCUSING ON ALL ASPECTS OF THE PATIENT'S LIFE.**

- **INCLUDE PARTICIPATION IN SUPPORT GROUPS.**

- **PROVIDE ACCESS TO EDUCATIONAL, VOCATIONAL AND EMPLOYMENT OPPORTUNITIES.**

- **FOSTER A SENSE OF BELONGING TO A COMMUNITY.**

Source: Institute of Medicine Report (1990).

# TRENDS AND ISSUES THAT IMPACT SUBSTANCE ABUSE TREATMENT

***Distinctions are being made between the "deserving" and "undeserving" poor, and substance abusers are coming out on the "undeserving" of benefits side.***

***Most people think of treatment success as immediate, complete abstinence forever. Often no provision is made for relapse, or understanding of the chronic and relapsing nature of the disease.***

Treatment on demand in an environment of reduced state and federal funding.

Gaps in the continuum of services.

Treatment for pregnant and parenting women and children.

Outreach, health care and treatment for injection drug users.

Treatment as an alternative to incarceration.

Treatment in the criminal justice system.

Access to primary health care for substance abusers.

Vocational training, employment counseling and referral, housing, and other ancillary services.

Exclusion of benefits to substance abusers:

- Supplemental Security Income (SSI).
- Limitations such as copayments and managed care gatekeeping procedures that preclude utilization of substance abuse treatment insurance coverage.
- Barring residence in public housing to those with a history of use of alcohol or drugs.

# MANAGED CARE, WELFARE REFORM AND SUBSTANCE ABUSE

***The advent of the QUEST program in 1994 has highlighted the need to assure the establishment of monitoring for contract arrangements with managed care systems that offer substance abuse treatment services.***

***Strategic issues:***

Qualification standards for staff who conduct assessments and determine level(s) and duration of treatment.

Patient placement criteria, and review and approval of placement and utilization review criteria.

Ensuring that substance abuse treatment core services that are not covered under traditional health plans (i.e., child care, transportation to treatment, vocational counseling, etc.) are provided.

Ensuring treatment diversity -- acceptability, accessibility, treatment intensity and comprehensiveness.

Developing information systems to provide timely and accurate information concerning benefit utilization levels.

Staff credentialing and/or licensure that recognizes the specialized knowledge, skills and abilities required of the clinician.

Licensure standards specific to substance abuse prevention and treatment.

Providing regulatory agencies that license treatment providers with information on substance abuse treatment. These entities would also license subcontractors that conduct assessments or make treatment decisions for health maintenance organizations (HMOs).

Reviewing HMO service plans and monitoring HMO compliance.

Ensuring that State licensure entities have the capacity and resources to enforce HMO compliance with State standards.

Ensuring that HMOs collect and report AOD treatment data comparison of managed care and fee-for-service data.

Monitoring the effects of reimbursement and capitation rates on access and quality of services and supporting outcome studies to demonstrate the degree to which managed care yields efficient use of services, enhances treatment outcomes and is cost-effective.

Advocating for special needs populations such as pregnant women, injection drug users, ethnic and racial minorities, the homeless and the disabled.

Assisting clients with appeals and grievances with the managed care system.

Supporting the provision of case management to assure a continuum of care and appropriate linkages to social services, primary health care and mental health services.

# NATIONAL TREATMENT PLAN INITIATIVE*

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) initiated a national dialogue – the *National Treatment Plan Initiative* – with the substance abuse treatment community to reach consensus on how substance abuse treatment services can be improved and paid for, so that those who need treatment can obtain it. Public hearings were convened to ensure that all voices – researchers, providers, recovery community and other community representatives – were part of the process.

The *National Treatment Plan* calls for investing for results to close the treatment gap; a commitment to quality treatment; "no wrong door" for entering treatment; changing attitudes that stigmatize those in recovery; and building partnerships so that research can be translated into practice in the field. A select list of the key recommendations noted the need to:

*Invest for results*

Close serious gaps in treatment capacity to reduce associated health, economic and social costs.

Establish standard insurance benefits for both public and private insurance that provide coverage for substance abuse and dependence equivalent to other medical conditions and that include a full array of appropriate treatment and continuing care.

Set reimbursement rates and funding levels to cover reasonable costs of providing care, including evidence-based practice improvements; capital improvements and reinvestment; workforce recruitment, retention, and development; and care for persons without public or private insurance.

*"No Wrong Door" to Treatment*

Require appropriate assessment, referral, and treatment in all systems serving people with substance abuse and dependence problems.

Ensure that in all systems individuals enter and become engaged in the most appropriate type and level of substance abuse treatment and that they receive continuing services at the level needed.

Apply a commonly accepted, evidence-based model for the continuum of services and care for substance abuse and dependence across health, human services, and justice systems as well as in the substance abuse specialty sector.

---

* Center for Substance Abuse Treatment, *Improving Substance Abuse Treatment: The National Treatment Plan Initiative, November 2000.*

*Commit to Quality*

Establish a system that more effectively connects services and research (CSR), with the goal of providing treatment based on the best scientific evidence. The system should specifically:

a) promote consistent communication and collaboration among service providers, academic institutions, researchers, and other relevant stakeholders; and
b) establish incentives and assistance for programs and staff in applying the new standards and treatment methods

Utilizing the CSR system, develop commonly accepted standards for the treatment field. Specifically:

a) define evidence-based standards for quality of care and practices that apply to all systems and payors;
b) derive or achieve consensus on critical data elements to measure quality of care and treatment outcomes for payors and providers;
c) establish standards for education, training and credentialing of alcohol and drug treatment professionals and for other health and human service providers; and
d) adopt best business practices for program management and operations.

Attract, support, and maintain a high quality, diverse workforce, responsive to the client population.

*Change Attitudes*

Engage the recovery community in all levels of discussion concerning substance abuse and dependence.

Conduct systematic research to better understand how people at risk for, suffering from, or in recovery from alcohol and/or drug abuse are affected by multiple and overlapping forms of stigma, and to understand more fully the views and attitudes of various population groups regarding substance abuse and treatment.

Conduct educational initiatives about alcohol and drug problems and effective treatments that promote the dignity of, and reduce stigma and discrimination against, people in recovery.

*Build Partnerships*

Encourage formation of effective groups that will:

a) unite people with alcohol and/or drug problems, people in recovery, their families and friends, and

b) bridge State/local systems of care and services that are responsible for various dimensions of the problem.

Create forums where government agencies and private organizations can collaborate.

Establish a Partnership Support Program that provides financial and other support to collaborative projects and groups.

Establish “partnership-building” as a priority objective in all appropriate programmatic and funding activities.

# HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

**Protecting the privacy of patients' health information.** Federal privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers took effect on April 14, 2003. Developed by the Department of Health and Human Services (HHS), these standards provide patients with access to their medical records and more control over how their personal health information is used and disclosed. They represent a uniform, federal floor of privacy protections for consumers across the country. State laws providing additional protections to consumers are not affected by this new rule.

Congress called on HHS to issue patient privacy protections as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA includes provisions designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information. The final regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically. Most health insurers, pharmacies, doctors and other health care providers were required to comply with these federal standards beginning April 14, 2003.

**Patient protections.** The new privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

> **Access to medical records.** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes. Health plans, doctors, hospitals, clinics, nursing homes and other covered entities generally should provide access these records within 30 days and may charge patients for the cost of copying and sending the records.
>
> **Notice of privacy practices.** Covered health plans, doctors and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Doctors, hospitals and other direct-care providers generally will provide the notice on the patient's first visit following the April 14, 2003, compliance date and upon request. Patients generally will be asked to sign, initial or otherwise acknowledge that they received this notice. Health plans generally must mail the notice to their enrollees by April 14th and again if the notice changes significantly. Patients also may ask covered entities to restrict the use or disclosure of their information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.

**Limits on use of personal medical information.** The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. To promote the best quality care for patients, the rule does not restrict the ability of doctors, nurses and other providers to share information needed to treat their patients. In other situations, though, personal health information generally may not be used for purposes not related to health care, and covered entities may use or share only the minimum amount of protected information needed for a particular purpose. In addition, patients would have to sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

**Prohibition on marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes. Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing. At the same time, the rule permits doctors and other covered entities to communicate freely with patients about treatment options and other health-related information, including disease-management programs.

**Stronger state laws.** The new federal privacy standards do not affect state laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any state law providing additional protections would continue to apply. When a state law requires a certain disclosure -- such as reporting an infectious disease outbreak to the public health authorities -- the federal privacy regulations would not preempt the state law.

**Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans and other covered entities take reasonable steps to ensure that their communications with the patient are confidential. For example, a patient could ask a doctor to call his or her office rather than home, and the doctor's office should comply with that request if it can be reasonably accommodated.

**Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider. Such complaints can be made directly to the covered provider or health plan or to HHS' Office for Civil Rights (OCR), which is charged with investigating complaints and enforcing the privacy regulation. Information about filing complaints should be included in each covered entity's notice of privacy practices.

**Health plans and providers**. The privacy rule requires health plans, pharmacies, doctors and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

**Written privacy procedures.** The rule requires covered entities to have written privacy

procedures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.

**Employee training and privacy officer.** Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed. If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.

**Public responsibilities.** In limited circumstances, the final rule permits -- but does not require -- covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an Institutional Review Board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.

**Equivalent requirements for government.** The provisions of the final rule generally apply equally to private sector and public sector covered entities. For example, private hospitals and government-run hospitals covered by the rule have to comply with the full range of requirements.

**Civil and criminal penalties.** Congress provided civil and criminal penalties for covered entities that misuse personal health information. For civil violations of the standards, OCR may impose monetary penalties up to $100 per violation, up to $25,000 per year, for each requirement or prohibition violated. Criminal penalties apply for certain actions such as knowingly obtaining protected health information in violation of the law. Criminal penalties can range up to $50,000 and one year in prison for certain offenses; up to $100,000 and up to five years in prison if the offenses are committed under "false pretenses"; and up to $250,000 and up to 10 years in prison if the offenses are committed with the intent to sell, transfer or use protected health information for commercial advantage, personal gain or malicious harm.

# SUBSTANCE ABUSE TREATMENT GOALS (2000-2004)

| | |
|---|---|
| **ADOLESCENT SUBSTANCE ABUSE TREATMENT** | Reduce the harm and restore life functioning for substance abusing and substance dependent adolescents by providing treatment services for substance abusing adolescents and their families. |
| **ADULT DETOXIFICATION AND FOLLOW THROUGH PROGRAMS** | Assure availability of a safe, controlled environment to assist chemically intoxicated individuals to withdraw from the physiological effects of alcohol and other drugs. |
| **ADULT SUBSTANCE ABUSE TREATMENT** | Reduce the harm and restore life functioning for substance abusing and substance dependent adults by providing substance abuse treatment and support services for substance abusing adults and their families. |
| **PREGNANT AND PARENTING WOMEN AND CHILDREN** | Reduce the impact of substance abuse on children and families by assuring availability of and access to appropriate treatment services for substance abusing women and their children. |
| **INJECTION DRUG USERS** | Reduce the spread of AIDS and other communicable diseases in the high risk substance abusing population by providing treatment for injection drug users. |
| **MENTALLY ILL SUBSTANCE ABUSERS** | Assure that substance abusers who also have a mental health problem are identified, supported and receive appropriate care. |
| **RECOVERY GROUP HOMES** | Support continuing recovery for substance abusers by assuring access to alcohol and drug free housing. |

# SUBSTANCE ABUSE PREVENTION

Substance abuse prevention is a dynamic and proactive process that attempts to reduce the supply and demand for alcohol and other drugs by focusing on:

The **agent**, which is defined as alcohol, tobacco, and other legal and illegal drugs.

The **host**, which is defined as the individual or group, their susceptibilities to alcohol and other drug-related problems, and their knowledge and attitudes that influence their behavior.

The **environment**, which is defined as the setting or context in which drinking and other drug-using behavior occurs or is influenced. The environment includes institutions and systems, such as schools and religious institutions, the community in which they exist, and the larger society with its norms and mores.

The challenge is to reduce the demand for alcohol and other drugs. Because the agent (drugs), the host (individual or group) and the environment (society) are interactive and interdependent, prevention efforts must deal with all three simultaneously.

*The six prevention strategies recommended by the Center for Substance Abuse Prevention are:*

**Community Mobilization**

**Information Dissemination**

**Prevention Education**

**Alternatives**

**Problem Identification and Referral**

**Environmental**

# PREVENTION PRINCIPLES

***Prevention is:***

- ***The promotion of constructive lifestyles and norms that discourage drug use.***

- ***The development of social and physical environments that facilitate drug-free lifestyles.***

***Prevention is achieved through the application of multiple strategies; it is an ongoing process that must relate to each emerging generation.***

*Prevention programs should:*

Enhance "protective factors" and reduce known "risk factors."

Target all forms of drug abuse, including the use of alcohol, tobacco and other drugs.

Be adapted to address the specific nature of the drug abuse problem in the local community.

Include skills to resist drugs when offered.

Strengthen personal commitments against drug use.

Increase social competency -- communications, peer relationships, self-efficacy and assertiveness -- to reinforce attitudes against drug use.

Include interactive methods, such as peer discussion groups.

Include a parents' or caregivers' component that reinforces what the children are learning and creating opportunities for family discussions about use of legal and illegal substances and family policies about their use.

Span the school – elementary, middle and high school -- career with repeat interventions to reinforce the original prevention goals.

Be age-specific, developmentally appropriate and culturally sensitive.

Be cost-effective; every dollar spent on drug use prevention can save communities 4 to 5 dollars in costs for drug abuse treatment and counseling.

NIDA (April 2, 1997)

# RISK AND PROTECTIVE FACTORS
# RELATED TO SUBSTANCE USE

## RISK FACTORS

Risk factors are characteristics of people or their family, school, and community environments that are associated with increases in alcohol, tobacco, marijuana, and other drug use. Seventeen factors have been identified that increase the likelihood that children and youth will develop problem behaviors such as substance abuse.

## PROTECTIVE FACTORS

Factors associated with reduced potential for drug use are called protective factors. Protective factors encompass psychological, behavioral, family, and social characteristics that can insulate children and youth from the effects of risk factors that are present in his/her environment.

### COMMUNITY

Alcohol and other drugs readily available.
Laws and ordinances are unclear or inconsistently enforced. Norms are unclear or encourage use.
Residents feel little sense of "connection" to community and communities are disorganized.
Neighborhoods have high transitions and residents are very mobile.
Communities have extreme poverty.

Opportunities exist for community involvement.
Laws and ordinances are consistently enforced.
Policies and norms encourage non-use.
Community service opportunities are available for youth.
Resources (housing, healthcare, childcare, jobs, recreation, etc.) are available.

### FAMILY

Family member with history of alcohol or other drug abuse.
Parents have trouble keeping track of their teens and do not have clear rules and consequences regarding alcohol and other drug use.
Parents use drugs, involve youth in their use ("get me a beer, would you?") or tolerate use by youth.
Family members have many conflicts.

Close family relationships.
Education is valued and encouraged, and parents are actively involved.
Copes with stress in a positive way.
Clear expectations and limits regarding alcohol and other drug use.
Encourages supportive relationships with caring adults beyond the immediate family.
Shares family responsibilities, including chores and decision-making.
Family members are nurturing and support each other.

### SCHOOL

Students lack commitment or sense of belonging at school.
High number of students fail academically at school.
Students exhibit persistent problem behaviors in school.

Communicates high academic and behavioral expectations.
Encourages goal-setting, academic achievement, and positive social development.
Provides leadership and decision-making opportunities for students.
Fosters active involvement of students, parents and community members.
Sponsors substance-free events.

### INDIVIDUAL

Youth associates with friends who use.
Has attitude that alcohol and drug use is "cool."
Begins using at a young age.
Has certain physical, emotional or personality traits.
Feels alienated and/or are rebellious.

Involved in alcohol and other drug-free activities.
Views parents, teachers, doctors, law enforcement officers and other adults as allies.
Has positive future plans.
Has friends who disapprove of alcohol and other drug use.

## COMMUNITY-, SCHOOL- AND FAMILY-BASED PROGRAMS

**Community-based programs** that are accompanied by school and family interventions strengthen norms against drug use in drug abuse prevention settings, including the family, the school, and the community. Community-based programs:

- Integrate the individual, family, school, media, community organizations and health providers.
- Use media and community education strategies to increase public awareness, attract community support, reinforce the school-based curriculum for students and parents and inform the public of the program's progress.
- Reach different populations at risk, and are of sufficient duration to make a difference.
- Follow a structured organizational plan that progresses from needs assessment through planning, implementation and review to refinement.
- Have specific objectives and activities, are time-limited, feasible (given available resources), and integrated so that they work together across program components.

**School-based programs** offer opportunities to reach all populations and also serve as important settings for specific subpopulations at risk for substance abuse. School-based programs:

- Reach children from kindergarten through high school, particularly during the critical middle school or junior high years.
- Contain multiple years of intervention throughout the middle school or junior high years.
- Use a well-tested, standardized intervention with detailed lesson plans and student materials.
- Teach drug-resistance skills through interactive methods --modeling, role-playing, discussion, group feedback, reinforcement and extended practice.
- Foster prosocial bonding to the school and community.
- Teach social competence -- communication, self-efficacy, assertiveness -- and drug resistance skills that are culturally and developmentally appropriate.
- Promote positive peer influence.
- Promote anti-drug social norms.
- Emphasize skills-training teaching methods.
- Include an adequate "dosage" – 10 to 15 sessions in year 1 and another 10 to 15 booster sessions.
- Retain core elements of the effective intervention design.
- Evaluated to determine whether the programs are effective.

**Family-based programs** have a greater impact than strategies that focus on parents only or children only. Family-based programs:

- Reach families of children at each stage of development.

Train parents in behavioral skills to:

- Reduce behavior problems in children.
- Improve parent-child relations, including positive reinforcement, listening and communication skills, and problem solving.
- Provide consistent discipline and rulemaking.
- Monitor children's activities during adolescence.

Include an educational component for parents with drug information for them and their children.

Are directed to families whose children are in kindergarten through 12th grade to enhance protective factors.

Provide access to counseling services for families at risk.

NIDA (April 2, 1997)

## SUBSTANCE ABUSE PREVENTION
## GUIDING PRINCIPLES AND BEST PRACTICES

**Guiding principles** are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none of the best practices are appropriate to the community's needs.

**Best practices** are those strategies, activities, or approaches which have been shown through research and evaluation to be effective at preventing and/or delaying substance abuse. Before selecting a best practice or applying the guiding principles, the community must conduct an assessment to identify the risk and protective factors that need to be addressed. Once risk and protective factor(s) to be addressed are identified, the following best practice(s) and/or guiding principles can be used --

"Best practices" are those strategies and programs which have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse and deemed research-based by scientists and researchers of the: National Institute for Drug Abuse (NIDA), Center for Substance Abuse Prevention (CSAP), National Center for the Advancement of Prevention (NCAP), Office of Juvenile Justice and Delinquency Prevention (OJJDP), and Centers for Disease Control and Prevention (CDC).

**Science-based prevention.** The "scientific method" makes use of strictly defined standardized procedures to determine how events are causally related. As science improves its methods, we benefit with increasing levels of certainty about the nature and extent of cause and effect relationships – we understand better what is required of us in terms of resources and effort to achieve specific outcomes. As we attempt to use the scientific method more systematically to identify knowledge, we also recognize the diversity of the way in which prevention programs are conducted and data extracted.

**Science-based actions and programs.** Researchers have reviewed numerous studies to determine the effectiveness of programs intended to prevent substance abuse. Best prevention outcomes are achieved by programs which:

- Focus on reducing known risk factors.
- Focus on increasing known protective factors.
- Address risk factors at appropriate developmental stages.
- Intervene early in the youth's life, before negative behavior stabilizes.
- Focus on individuals and communities at greatest risk.
- Address multi-risk issues with multiple strategies, across multiple environments.
- Address cultural and ethnic factors.

# SUBSTANCE ABUSE PREVENTION PROGRAMS AND STRATEGIES

*Types of programs:*

Universal programs reach the general population – such as all students of a school.

Selective programs target at-risk or subsets of the general population – such as children of drug users or poor school achievers.

Indicated programs are designed for people who are already experimenting with drugs or who exhibit other risk-related behaviors.

*Basic prevention strategies:*

Raise awareness of the dangers of drug use and the benefits of constructive behavior.

Promote good parenting skills and strengthen the family as the first defense against drug abuse.

Build academic/vocational skills to allow individuals the potential of developing into contributing members of society.

Provide mentoring and positive role modeling for youth.

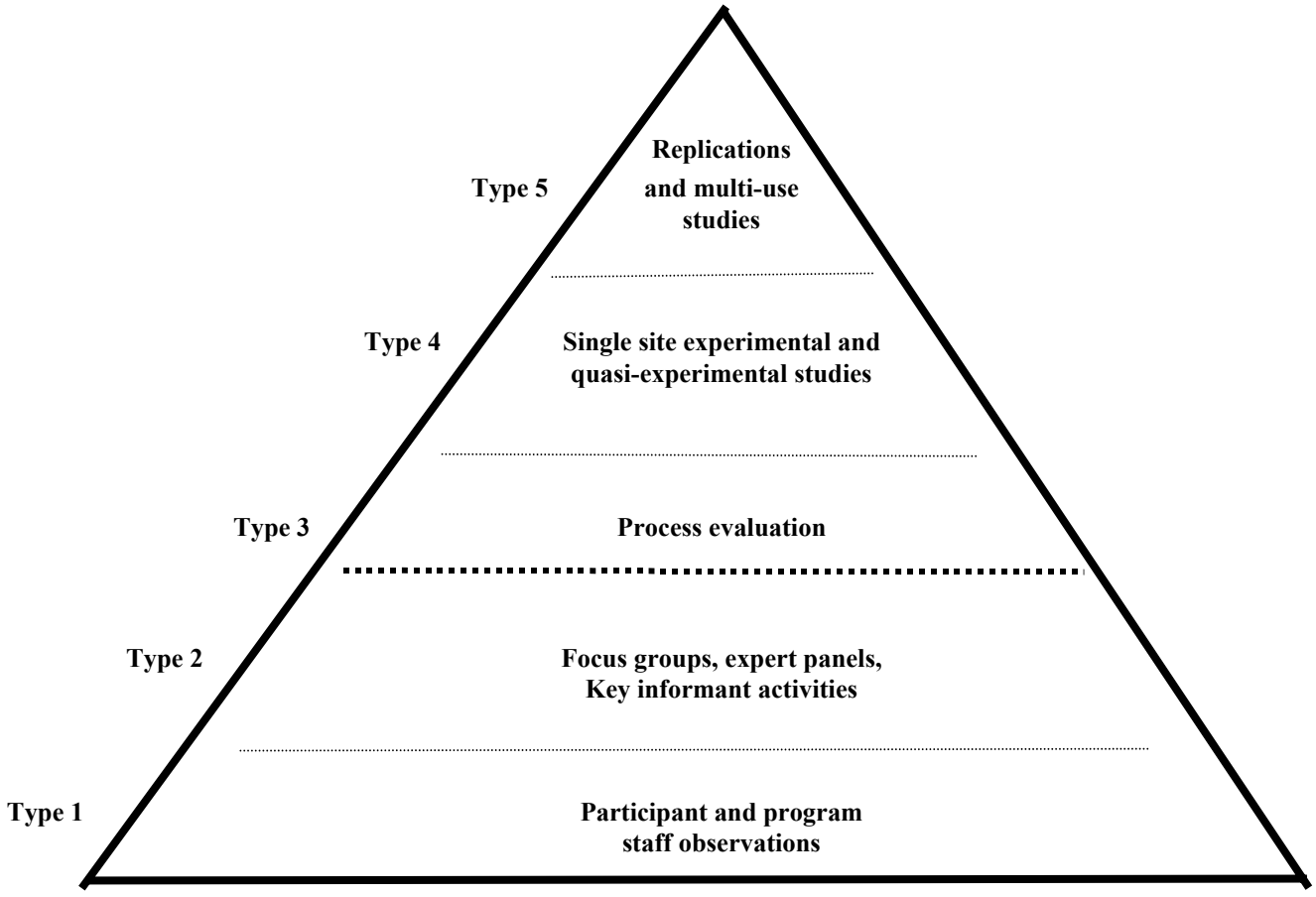
Build social skills to enable the development of strong self-image that leads to positive life decisions.

Mobilize communities to establish environment enhancing positive personal development.

Strengthen and support policies that promote healthy lifestyles and change community norms.

Utilize research based best practices in programming.

There are numerous data collection techniques that are used to gain knowledge in the substance abuse field. The techniques are mapped onto a pyramid in order to reflect proportionately how much information is generated by particular techniques. Ironically, as indicated in the figure, the more sophisticated and traditionally accepted "scientific" approaches represent a small portion of data collection efforts, yet the information derived from such studies comprise a significant portion of the formal knowledge base. Still, it is important to value the diversity of these approaches to learning, as they all can be based on sound scientific principles, and all can add knowledge concerning constructing and implementing successful prevention interventions.



# PREVENTION GOALS (2000-2004)

| | |
|---|---|
| **YOUTH LEADERSHIP DEVELOPMENT** | Provide youth with knowledge and leadership skills to implement alcohol and other drug free activities. |
| **PRIMARY PREVENTION PROJECTS FOR YOUTH** | Prevent the onset of alcohol, tobacco and other drug use among high-risk youth. |
| **COLLEGE AGE POPULATION** | Promote and develop a drug-free lifestyle for the college age population. |
| **ELDERLY PRESCRIPTION ABUSE PREVENTION** | Reduce prescription misuse and increase knowledge of the dangers of interactive effects of medicine in the elderly. |
| **NATIVE HAWAIIAN AGRICULTURAL PROJECT** | Promote culturally rich Native Hawaiian prevention education and wholesome lifestyle role modeling to elementary grade children. |
| **NATIVE HAWAIIAN EX-OFFENDER PREVENTION PROGRAM** | Improve the quality of life of Native Hawaiian ex-offenders by incorporating a substance abuse prevention project that employs traditional Native Hawaiian healing methods. |
| **STATE RESOURCE CENTER (RADAR)** | Assure a statewide reservoir of current alcohol, tobacco and other drug information and the availability of the most current information on substance abuse prevention and treatment services. |
| **TARGETED EDUCATION/ PREVENTION** | Increase professional and public awareness of the health and safety risks associated with the use and abuse of alcohol and other drugs. |
| **PUBLIC AWARENESS CAMPAIGN** | Promote a wellness model to influence the behaviors and attitudes of the public regarding alcohol and other drugs. |
| **UNDERAGE DRINKING** | Increase awareness of the underage drinking problem to prevent early onset drinking. |

**§321-193 Duties and responsibilities of department**. The department shall:

(1) Coordinate all substance abuse programs including rehabilitation, treatment, education, research, and prevention activities.

(2) Prepare, administer, and supervise the implementation of a state plan for substance abuse which may consist of a plan for alcohol abuse prevention and a plan for drug abuse prevention.

(3) Identify all funds, programs, and resources available in the State, public and private, and from the federal government which are being used or may be used to support substance abuse prevention, rehabilitation, treatment, education, and research activities.

(4) Be the designated agency required by, and receive and administer all available substance abuse funds including but not limited to funds received from, the federal government under Public Law 92-255, Public Law 91-616, Public Law 91-211, and Title IVA and XVI of the Social Security Act or other subsequent Acts of Congress which may amend or succeed such Acts.

(5) Encourage and coordinate the involvement of private and public agencies in the assessment of substance abuse problems, needs, and resources.

(6) Coordinate the delivery of available funding to public and private agencies for program implementation.

(7) Establish mechanisms and procedures for receiving and evaluating program proposals, providing technical assistance, monitoring programs and securing necessary information from public and private agencies for the purposes of planning, management, and evaluation.

(8) Review the state plan for substance abuse annually for the purpose of evaluation and make necessary amendments to conform with the requirements of federal or state laws.

(9) Do all things necessary to effectuate the purposes of this part.

(10) Certify program administrators, counselors and accredit programs related to substance abuse programs in accordance with rules to be promulgated by the department. [L 1975, c 190, pt of §2; am L 1977, c 108, §1]